(B) The portion of teaching physicians' salaries and fringe benefits that are related to the time spent teaching and supervising residents.

(C) Facility overhead costs that are allocated to direct graduate medical education.

(ii) The following costs are not allowable graduate medical education costs—

(A) Costs associated with training, but not related to patient care services.

(B) Normal operating and capital-related costs.

(C) The marginal increase in patient care costs that the RHC or FQHC experiences as a result of having an approved program.

(D) The costs associated with activities described in § 413.85(h) of this chapter.

(7) Payment is equal to the product of—

(i) The RHC's or the FQHC's allowable direct graduate medical education costs; and

(ii) Medicare's share, which is equal to the ratio of Medicare visits to the total number of visits (as defined in § 405.2463).

(8) Direct graduate medical education payments to RHCs and FQHCs made under this section are made from the Federal Supplementary Medical Insurance Trust Fund.

[43 FR 8261, Mar. 1, 1978. Redesignated and amended at 57 FR 24977, June 12, 1992; 60 FR 63176, Dec. 8, 1995; 61 FR 14658, Apr. 3, 1996; 63 FR 41002, July 31, 1998; 66 FR 39932, Aug. 1, 2001; 70 FR 47484, Aug. 12, 2005]

§ 405.2469 Federally Qualified Health Centers supplemental payments.

Federally Qualified Health Centers under contract (directly or indirectly) with Medicare Advantage organizations are eligible for supplemental payments for covered Federally Qualified Health Center services furnished to enrollees in Medicare Advantage plans offered by the Medicare Advantage organization to cover the difference, if any, between their payments from the Medicare Advantage plan and what they would receive under the cost-based Federally Qualified Health Center payment system.

(a) *Calculation of supplemental payment.* (1) The supplemental payment for Federally Qualified Health Center covered services provided to Medicare patients enrolled in Medicare Advantage plans is based on the difference between—

(i) Payments received by the center from the Medicare Advantage plan as determined on a per visit basis; and

(ii) The Federally Qualified Health Center's all-inclusive cost-based per visit rate as set forth in this subpart, less any amount the FQHC may charge as described in section 1857(e)(3)(B) of the Act.

(2) Any financial incentives provided to Federally Qualified Health Centers under their Medicare Advantage contracts, such as risk pool payments, bonuses, or withholds, are prohibited from being included in the calculation of supplemental payments due to the Federally Qualified Health Center.

(b) *Per visit supplemental payment.* A supplemental payment required under this section is made to the Federally Qualified Health Center when a covered face-to-face encounter occurs between a Medicare Advantage enrollee and a practitioner as set forth in § 405.2463.

[70 FR 70329, Nov. 21, 2005, as amended at 71 FR 9460, Feb. 24, 2006]

§ 405.2470 Reports and maintenance of records.

(a) *Maintenance and availability of records.* The rural health clinic or Federally qualified health center must:

(1) Maintain adequate financial and statistical records, in the form and containing the data required by CMS, to allow the intermediary to determine payment for covered services furnished to Medicare beneficiaries in accordance with this subpart;

(2) Make the records available for verification and audit by HHS or the General Accounting Office;

(3) Maintain financial data on an accrual basis, unless it is part of a governmental institution that uses a cash basis of accounting. In the latter case, appropriate depreciation on capital assets is allowable rather than the expenditure for the capital asset.

(b) *Adequacy of records.* (1) The intermediary may suspend reimbursement if it determines that the clinic or center